Fields of Opportunities

STATE OF IOWA

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DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

INFORMATIONAL LETTER NO. 758 October 10, 2008

TO: Iowa Medicaid Home Health Agency Providers

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise

RE: Changes for Filing Home Health Claims and Home Health Services Quality Review

EFFECTIVE: January 1, 2009

The Iowa Medicaid Enterprise (IME) is pleased to announce a significant change in the claims submission process for Medicaid's home health agency providers.

- **Effective January 1, 2009 Medicaid home health agencies will no longer be required to submit copies of home health service case notes and plans of care for each Medicaid member**.
- **Home Health providers are encouraged to file claims electronically. Sign up now!** Elimination of this paper documentation requirement offers Medicaid home health providers the opportunity to fully benefit from the ease and accuracy of electronic claim submission. This change in the claims submission process applies to all services provided by Medicaid home health agencies.
- **Submission of paper case notes and plans of care for all Medicaid claims will be replaced by a new 'post-pay' Quality Review process, described below.**

Preparing for Electronic Claims Submission
Electronic billing of home health claims will require enrollment with EDISS and installment of PC-ACE software or other compatible billing software. If your agency is not currently billing electronically, PC-ACE billing software is available to Iowa Medicaid providers without cost.

IME Provider Services will be providing outreach and training to assist home health agencies with the electronic billing process and implementation. These outreach and training activities will be outlined in a forthcoming informational letter.

HOME HEALTH SERVICES QUALITY REVIEW

The January 1, 2009 date also marks the implementation of a revised quality review of home health services offered through the Medicaid State Plan home health benefit. The State Plan home health benefit includes the following services:

- Skilled Nursing
- Home Health Aid
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services

Please note: This quality review does not include reviewing claims for the prior authorized services through the Care For Kids (EPSDT) program, which will continue with its existing review processes. These services are Private Duty Nursing and Personal Cares.

Following is an overview of this quality review process:

- A random sample of paid home health claims will be drawn on a monthly basis for the preceding list of services.
- Correspondence from IME Medical Services will be issued to the home health agencies serving the Medicaid members included in the random sample. Documentation specific to each Medicaid member will be requested. The documentation will include, but is not limited to, the plan of care, OASIS assessment, and documentation of home health services. The due date for the requested documentation is 30 days after the correspondence date. After an additional 15 days, a technical denial will be issued if the requested documentation is not received. The technical denial will initiate a claims adjustment process that will recoup the reimbursement received for the Medicaid member from future payment.
- If the documentation requested is received timely, the quality review will include:
    - A review of the plan of care. The plan of care must include all of the services that the Medicaid member receives.
    - A comprehensive medical necessity review of all services that the member receives includes, but is not limited to, Medicaid State Plan home health services, other Medicaid State Plan services, Medicaid Waiver Home and Community Based Services, and In Home Health Related Care
    - A review of the documentation to insure that all services were provided as reimbursed and were medical necessary
- At the completion of the quality review, one of the following outcomes will be communicated to the home health agency provider for each Medicaid member in the random sample:
    - Confirmation of the accuracy of the claim reimbursement
    - Additional documentation is needed
    - Modification of the claim reimbursement. The amount of the original reimbursement will be reduced because documentation did not support medical necessity for the services billed. A notice of decision (NOD) will be issued to the Medicaid member and to the home health agency that will explain why the reimbursement amount will be modified. A claims adjustment process will be initiated that will recoup the overpayment from future payment.
    - Denial of the claim reimbursement. The total amount of the original reimbursement is denied because documentation did not support medical

necessity for the services billed. A notice of decision (NOD) will be issued to the Medicaid member and to the home health agency that will explain why the reimbursement amount is being recouped. A claims adjustment process will be initiated that will recoup the overpayment from future payment.

Please watch for the forthcoming informational letter that will outline the outreach and training efforts that IME Provider Services will be implementing to offer this electronic billing option to Iowa Medicaid home health agency providers. If you have immediate questions regarding electronic billing or if you would like to sign up for electronic billing now, please contact IME Provider Services at 515-725-1004 (local) or 800-338-7909, or by e-mail at: imeproviderservices@dhs.state.ia.us.